



Health History

Date: _____

Name: _____ Date of Birth: _____ Height _____ Weight: _____

Referral: _____ Handedness: Right / Left

Primary care physician _____

Do you have access to a health club or swimming pool _____

Occupation: _____

Are you currently being treated for, or have you in the past been treated for any of the following:

Arthritis local/systemic	Yes	No	Cancer	Yes	No
Chemical/alcohol dependency	Yes	No	Diabetes	Yes	No
GI/digestive disturbances	Yes	No	Heart Disease	Yes	No
Infectious disease	Yes	No			
Psychological/mood disorder	Yes	No			

If yes to any of the above, please explain:

Please indicate all major surgeries – type and date of surgery. List most recent, first:

Please list current medications:

Are you using vitamins or supplements?

What brings you in to see OPT?

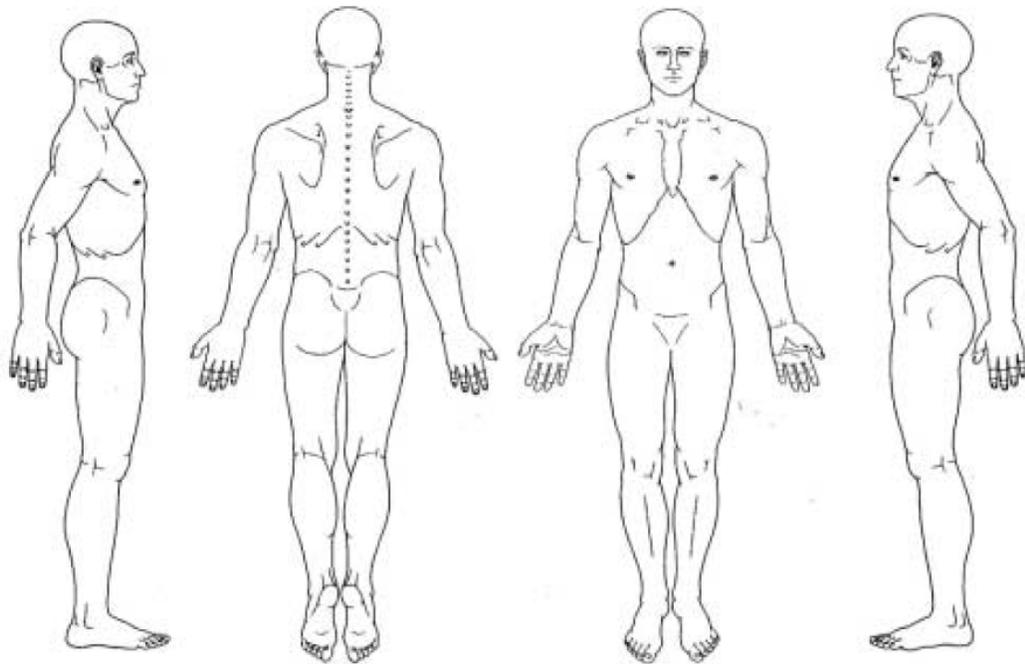
Onset of your concerns?

Have you had this before? _____

If so, how was it treated?

What would you like to accomplish with this course of care? Your expectations are to;

Use the diagram below to highlight areas of concern.



What is the nature and location of your primary concern?

What makes it worse?

What makes it better?

Is it constant or intermittent?

Are you sleeping well? Y/N- How many quality hours do you usually have each night? _____

What position do you classically sleep? _____ Are you a side sleeper Y/N?

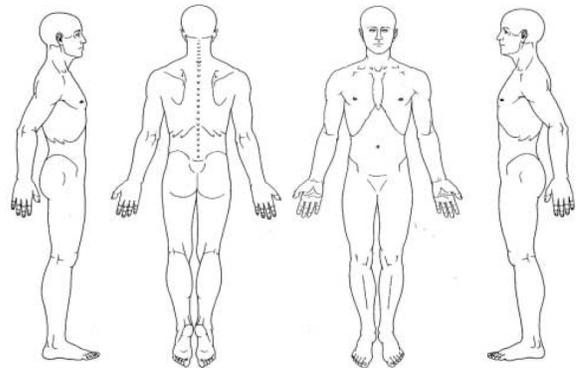
Do you feel different from morning to evening?

Has the above concern been evaluated by a physician?

If yes, were there diagnostic tests taken?

DO NOT WRITE IN THE SPACE BELOW.

Posture/gait:



Motion Testing:

Strength Testing:

Neuromuscular Testing:

SLR

Dural sleeve

Strength, sensory, and reflex

Special screening Tests:

Manual screening and Myo-fascial patterning:

Today's session:

Summary of findings

- 1.
- 2.
- 3.

Impression:

Plan of Care:

Goals to achieve: _____ P.T.